Managed Care Organizations and Health Plans

Summary: This project aims to understand and improve decision-making process of managed care organizations, health plans, and other providers of health care services regarding resource allocation and other ethical issues.

Section: Ethics and Health Policy— Unit on Prioritization

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Background: There is tremendous dissatisfaction with managed care, health plans, pharmaceutical companies, and other providers of health care services. The public feels most managed care plans, health plans, and pharmaceutical benefits companies are more interested in profits than in caring for patients. These insurers, health plans and providers feel maligned and misunderstood; they feel caught between the need for cost control and the public and physician resistance to any limitations on care.

Over the last few years, the tensions between the public, physicians, and managed care, health plans, pharmaceutical companies, and other providers of health care services have erupted in many controversies. To many, these controversies represent the clash of conflicting interests. Others view these controversies as the consequences of the imperatives of for-profit medicine.

Different diagnoses lead to different proposed solutions. Some recommend legislation or regulation, such as the patients' bill of rights. Others, following the successful tobacco litigation, have advocated law suits.

We have argued for an alternative perspective. The rapid shift in the health care system over the last decade from a patient-centered, fee-for-service model to a population-based, capitated model constitutes a major shift in the central ethical values that guide the medical system and practice. At base it shifts the focus from doing everything possible for the individual patient to incorporating resource allocation decisions into policy formulation and health care decisions that apply to populations of patients. Consequently, much of the controversy can be send as the consequence of uncertainty and conflict over ethical values that should guide health care policies and practices. This perspective suggests that progress in resolving these controversies can be made by some careful attention to the ethical issues underlying these conflicts, by suggesting ways to balance conflicting ethical values, and by examining how different health care organizations actually address these conflicting values.

Objectives:

1) Examine and evaluate how different health care organizations characterize and address ethical issues, especially regarding resource allocation.
2) Identify best practices in addressing ethical issues in health care organizations.

Methodology: We developed a collaboration with the Center for Ethics in Managed Care at Harvard Medical School to examine how different types of managed care organizations address ethical issues. With the emphasis on conducting case studies to identify best practices, the team consulted with Steve Shortell who had conducted a similar study focused on the development, governance, and management of organized health care delivery systems. After this consultation we adopted a multi-step methodology:

1) Convened a meeting of senior executives of managed care organizations, health plans and other delivery systems to identify key problems they confront.
2) Classification of these problems by the research team into ten specific ethical issues confronting managed care organizations, health plans and other delivery systems. Issues include conflict of interest, adoption of new technologies, medical necessity determinations, consumer empowerment.
3) Delineation by the research ream of relevant values and value conflicts for each of the ten issues.

4) Selection of a range of managed care organizations, health plans and other delivery systems to reflect different types of organizations including for-profit, not-for-profit, academic, and religious, as well as organizations in different geographic areas.
5) Collection and analysis of organizational documents relevant to each ethical issue.
6) Site visits to each organization to examine and observe practices, and to interview executives, managers, physicians, and consumers.
7) Synthesize information from documents and site visits into a narrative assessment of how ethical issues are addressed and ethical values balanced including identification of best practices.
8) Revision of the narrative assessment based upon response from the managed care organizations, health plans and other delivery systems.
9) Dissemination of the best practices.

Part way into this project, two changes occurred to focus attention on the development and implementation of pharmacy benefits programs. First Viagra was approved and many health care organizations sought ways to limit their coverage of this drug. Similtaneously, other new costly drugs were approved and pharmaceutical costs increased and many health care organizations developed new benefits management approaches to contain costs. We thought it would be important to elucidate how different health care organizations were making drug coverage decisions. We selected four pharmaceutical agents—Viagra, Zyban (for smoking control), Enbrel (an anti-TNF antibody for rheumatoid arthritis), and Celebrex (a Cox-2 inhibitor for osteoarthritis, rheumatoid arthritis, and other conditions requiring anti-inflammatory agents). We identified health plans from the 1997 AAHP directory, insurance carrier lists from state insurance commission offices to represent a cross section of health care organizations that varied by size, tax status, and geography. Ultimately, 53 organizations provided data on their coverage policies for these 4 agents.

Results: We recruited geographically diverse health care organizations, including 2 for-profit managed care companies, 4 not-for profit managed care companies of which one was a Blue Cross & Blue Shield plan, 1 one affiliated with an academic medical center, 1 one hospital organization which was religiously affiliated. Site visits were conducted between .

We delineated explicit criteria for best practices: 1)There was a coherent formulation of an area of difficulty embodying conflicting interests and values; 2) There was a plan of considered innovative action to managed the value conflicts; 3) There was a set of consistently applied procedures integrated into the organizations functioning that could plausibly implement the plan; and 4) There was a mechanism to evaluate the effectiveness of the implementation strategy in meeting its objectives.

Data on the coverage decisions regarding the 4 drugs is summarized in the table:

Limitation	Viagra	Zyban	Enbrel	Cox-2
Some Coverage	72%	49%	96%	92%
Covered without limitation	2%	6%	21%	19%
Exclusion	89%	74%	2%	11%
Limitation on quantity or duration	64%	30%	0%	8%
Prior authorization	21%	11%	68%	34%
Tiered Co-payment	2%	4%	4%	13%

Importantly, for-profit and not-for-profit organizations were just as likely to cover Viagra while not-for-profit organizations were more likely to cover Zyban.

The most commonly used strategy to limit access was limiting the quantity or duration of use of the drugs with prior authorization second most common strategy. Furthermore, many organizations indicated they stopped using prior authorization because the administrative costs exceeded the savings.
In making coverage decisions 30% of organizations used information provided by pharmacy benefit managers with for-profit organizations relying on them significantly more than not-for-profit organizations. 38% rely on pharmacoeconomic data. Only 1 of the 53 organizations solicited the views of their plan members. The top factors in determining coverage decisions were FDA approval (50%) drug acquisition costs (46%) and availability of alternatives (44%).

Overall, aside from Zyban there did not seem to be substantial differences in coverage decisions between for-profit and not-for-profit organizations. In addition, while cost was the third most important factor in making coverage decisions, it did not appear determinative alone as many companies covered Enbrel and the Cox-2 inhibitors but not Zyban which was much cheaper. Instead, it appeared that values—greater weight to medical benefit over "lifestyle"—appeared to inform coverage decisions.

Future Directions: This work will take two paths in the future. First, in conjunction with Merek-Medco the large pharmacy benefits management

company, the Department is planning a major survey of members about their views regarding allocating of health care resources for pharmacy benefits. The survey will examine whether the members think they have an obligation to save money or whether they think the money they spend is their own money; whether they think their saving money is of benefit to other members; and the reasons why the members might be resistant to use pharmaceutical benefits that save money. This survey should help understand whether members understand the pooling of resources in an insurance pool means that resources saved benefit other members or whether they are resistant to save resources because they believe the money will only go to increased executive salaries or shareholder profits rather than member health benefits.

A second future project is to work with various health plans to integrate ethical policies into their practices. It is our perception that decision-makers in health plans are largely interested in having ethical policies. The chief barriers to implementing such policies are 1) lack of awareness of ethical policies; 2) risk aversion combined with concern about the probable success of the policies to make decision-makers hesitant to implement new policies; 3) availability of these policies in a "work plan" format that match the standard format used by decision-makers in health plans; and 4) lack of technical assistance and consultation services to help implement these policies. This project aims to overcome each of these barriers by creating a consortium of health plans from which representatives will be selected. These representatives with identify key topics on which policies would be desirable. They would then work with the research team members to develop policies and transform them into "work plans." Through conferences and other contacts the works plans will be disseminated. Partnerships will be developed with health plans interested in implementing particular policies. The research team will provide technical assistance and also consultation with representatives from other health plans that have actually implemented the ethical policies.

Publications:

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